MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
SEPTEMBER 23, 1997 STUDY SESSION -- NOTES

Tuesday, September 23, 1997
9:30 A.M. until 4:30 P.M.
1201 K Street, 12th floor - California Room, [California Chamber of Commerce Building]
Sacramento, California

I. CALL TO ORDER[Chairman Alain Enthoven, Ph.D.] - 9:00 A.M.

The sixth study session meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. ROLL CALL

The following Task Force members were present: Dr. Bernard Alpert; Dr. Rodney Armstead; Ms. Rebecca Bowne; Dr. Donna Conom; Dr. Alain Enthoven; Ms. Nancy Farber; Ms. Jeanne Finberg; Hn. Martin Gallegos; Dr. Bradley Gilbert; Ms. Diane Griffiths; Mr. William Hauck; Mr. Mark Hiepler; Dr. Michael Karpf; Mr. Peter Lee; Dr. J.D. Northway; Ms. Maryann O'Sullivan; Mr. John Perez; Mr. John Ramey; Mr. Anthony Rodgers; Dr. Helen Rodriguez-Trias; Ms. Ellen Severoni; Dr. Bruce Spurlock; Mr. Ronald Williams; Mr. Allan Zaremberg; and Mr. Steve Zatkin.

The following ex-officio members were also present: Ms. Kim Belshe; Ms. Marjorie Berte; Mr. Keith Bishop; and Mr. David Werdegar.

III. OPENING REMARKS - 9:20 A.M.

Chairman Enthoven stated that the following are potential areas of Task Force recommendations:

- ✓ restructuring the dispute resolution process
- ✓ streamlining the regulatory process (public and private sectors)
- ✓ establishing new limits on provider incentives and how doctors are paid
- ✓ expanding consumer choice and information disclosure accessibility
- ✓ improving avenues for consumer involvement
- ✓ establishing risk adjustment procedures
- ✓ applying new quality information practices to allow OSHPD to publish better risk adjustment data
- ✓ the reconfiguration of the state government regulatory structure
- ✓ allowing innovative information dissemination
- ✓ moving towards managed care improvement
- ✓ encouraging multiple choice of plans (may need ERISA reform).

Chairman Enthoven also provided members with the day's tentative schedule and asked Ms. Alice Singh, Deputy Director for Legislation and Operations, to address the Task Force on a few administrative details. Deputy Director Singh said that a letter signed by Executive Director Phil Romero faxed to members earlier in the week provided members with a proposed development schedule for the Task Force's final report. The letter further confirmed the due dates of each Expert Resource Group paper.

Deputy Director Singh then reported that staff are awaiting information pertaining to the status of the budget trailer bill containing language which would allow Task Force members to be reimbursed for travel costs associated with attending Task Force meetings and hearings.

Deputy Director Singh also said that given that Task Force members have recently received numerous correspondence and reports form interested parties at the Sacramento office, instead of mailing these documents, staff compiled them and placed them in manila folders in each member's desk area. Included in these folders was a memo written by Dr. Northway entitled, "Children: a vulnerable population".

IV. REPORTS AND PRESENTATIONS

A. Expert Resource Group Report and Discussion [1 hour] - 10:00 A.M.

1. Consumer Involvement, Communication and Information [Task Force members Jeanne Finberg and Ellen Severoni]

Ms. Finberg stated that the way consumers receive their health care has changed dramatically with the shift from fee for service to managed care. She felt that many consumers do not understand or have not been able to adapt positively to these changes. She stated that consumers have scanty information to help them choose their health plan medical group or primary care physician. Information that is available to them is often incomplete, biased, unintelligible, or not helpful. Moreover, Ms. Finberg stated that consumers often are not confident they are getting the necessary information to make important decisions and they are unsure how to get help when they have problems with their health care.

Ms. Finberg outlined principles for consumer information. She stated that consumers should have useful, unbiased, standardized information that would assist in decision-making. In addition, consumers should have information about the managed care system, how it might affect their health care, how to navigate their health plan, and how to access their plan's internal grievance process, and external resources, and the relevant regulatory authorities. She noted that there may need to be information specifically designed to meet the needs of certain populations, such as patients with chronic conditions. She also stated that full and accurate disclosure fosters competition and best practices. Mr. Williams added that information should be available in different forms and languages to meet consumers' needs.

Dr. Karpf then discussed standardization. He said that standardization would allow consumers to make appropriate comparisons and would make information dissemination more efficient for providers. Responding to a question from Dr. Gilbert, Dr. Karpf clarified that the data elements have to be standardized, but not necessarily the language.

Ms. Finberg mentioned some options to improve consumer information, including developing basic information about how the managed care system works and how to pursue a grievance; developing incentives for plans to provide standardized information on quality of care, rules, restrictions, and options for their members; mandating reports of standardized information to an independent party; requiring health plans and medical groups to disclose information on treatment guidelines and/or financial incentives; developing incentives or mandates to improve quality measures; and requiring governmental agencies to work cooperatively in producing consumer information and responding to consumer complaints. Ms. Finberg stated that consumer information could be provided by plans, groups and providers working cooperatively, by an independent entity, or by a government agency.

Mr. Williams and Mr. Zaremberg questioned whether these issues were unique to managed care or endemic throughout health care. Mr. Zaremberg further questioned whether this information should be

provided to consumers in advance, given that most people do not look at this type of information until they are having a problem.

On the topic of who should provide the information, Mr. Zaremberg cautioned against creating a new government agency without knowing whether the public would find this information useful. Chairman Enthoven noted that due to Fifth Amendment rights and other issues regulated entities sometimes fail to disclose information to government agencies. He favored indirect regulation through the buyer-seller relationship.

Task Force members discussed the information provided by one purchasing group, the Pacific Business Group on Health (PBGH). Mr. Zaremberg asked if PBGH's information had been tested to see how well it satisfied consumers' needs and whether it should be a model. Dr. Spurlock stated that PBGH had done some focus group tests about how to present the information but did research how useful the information actually is to consumers.

Regarding the range of options Ms. Finberg presented, Mr. Lee suggested the Task Force focus on providing information on how to use the managed care system. Regarding disclosure, Mr. Lee felt this information should not be contained in the evidence of coverage (EOC) documents. Regarding standardization, Mr. Lee felt there were two issues to be addressed: standardization of data collection and standardization of the dispute resolution process.

Mr. Williams argued for standards (assurances that products meet established guidelines) rather than standardization. He also advocated developing methods to get consumers more involved in the decision-making process and understanding their choices. Mr. Zaremberg noted that, particularly for small and medium size businesses, employers often make decisions for consumers. He suggested developing information that would be helpful to agents, brokers, and businesses.

Next, Ms. Severoni discussed consumer involvement. She suggested that public values should be incorporated into health plans' policies and practices, but that there is a dearth of consumer involvement in health care decision making. She felt the industry needs strong incentives to promote consumer involvement. She outlined two consumer involvement mechanisms: member advisory committees and feedback models.

Task Force members discussed the paper's "guiding principles" for consumer involvement. Mr. Williams felt that plans were already attempting to involve their consumers through focus groups, member advisory committees on product designs, etc. Both he and Mr. Zatkin stated that there was room for improvement.

Dr. Alpert stated that the ultimate time for consumer involvement is at the time the patient is contemplating care. He felt the patient is most vulnerable at that point, most in need of information, and least satisfied with the information available. Dr. Spurlock agreed that this kind of individual involvement is as important as group involvement through advisory panels and such activities.

Hn. Mr. Gallegos clarified the distinction between advertising (and the focus groups often used to develop advertising) and the kind of information and consumer involvement this paper discussed.

On the issue of incentives to foster consumer involvement, Mr. Williams felt that if consumer involvement would increase plan enrollment, that would be a strong incentive.
Ms. Finberg commented that plans are very concerned with consumers while the consumer is deciding which plan to choose, but once the consumers pick a plan they really do not have the mechanisms to be able to improve their relationship with their providers.

Ms. Severoni suggested that purchasers might create incentives by requiring consumer feedback mechanisms in their plan contracts.

Mr. Zatkin described consumer involvement in the development of Kaiser's breast cancer testing guidelines. Dr. Karpf questioned the validity and legitimacy of public involvement in treatment guidelines because he felt they should not be developed through public consensus but through careful investigation and evaluation by physicians. Mr. Zatkin stated that plans ought to be able to explain the basis for their guidelines and listen to consumer input. Dr. Spurlock stated that in medicine there is a lot of uncertainty. Whenever there is uncertainty, the values of the patient become much more important on how providers proceed.

Ms. Severoni discussed the paper's first recommendation, that government purchasers and plans should develop and implement formal consumer feedback mechanisms that result in useful measures of the extent to which the plan and their provider group is successful in involving consumers in organizational design and decision making. Ms. Bowne disagreed with this recommendation, stating that while consumer involvement is important, "you could have very happy but very sick consumers." Ms. Bowne also felt that plans are involving consumers and criticized Ms. Severoni for over-generalizing about the lack of consumer involvement. Ms. Bowne did suggest, however, that there could be more consumer testing of the information plans provide. Mr. Williams felt that the cost of providing all of this information and involvement would need to be considered.

B. Presentation and Discussion - 11:30 A.M.

1. <u>Risk Adjustment</u> [Harold S. Luft, Ph.D., Director, Institute for Health Policy Studies and Professor of Health Policy and Health Economics at the University of California, San Francisco; and Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board]

Dr. Luft started the discussion by raising the issue of how to get plans to want to take care of sick people. He described risk adjustment - adjusting for differences in enrollee risks that might account for higher or lower expenditure in a health plan - as a way to address the issue.

Risk adjustment, Dr. Luft said, can take many types risks into account. First, there is the risk of an event's occurrence. The probability may vary and is often unknown. He gave the example of birth. We know genetically that women are much more likely than men to bear children. It is known that there are other probabilities that will increase or decrease the likelihood that a woman might have a child in the next year. Second, there is the risk of the need for medical care. That is, the amount of medical care needed given that an event happens. All of these risks affect the amount of money that will be spent on the person's care.

Dr. Luft stated that plans should be held accountable for those things they can control but not for things they can't control. If, for example, a provider happens to attract more women who are going to give birth, the plan should pay that provider more. What is needed, he said, is a method adjust the payment to the plan to reflect the differences in risk that the plan cannot control. Such predictions cannot be made at the individual level, but can be made for large groups. He estimated that roughly twenty percent of the variation in health care expenditures can be explained by non-random events and that current statistical models can account for roughly forty percent of those non-random events, which he and other experts felt was adequate to begin using the models to risk adjust payments to health plans.

Dr. Luft stated that if plans are paid more to take care of sicker patients they may actually find such patients attractive, which is not the case now under non-risk-adjusted capitation. He explained that currently plans are paid a flat rate for their members' care, regardless of their members' health status. Those plans that attract sicker patients have to provide more and/or more expensive services with the same amount of money as plans that attract healthier patients. Therefore, plans that attract sicker patients run the risk of going bankrupt. With risk adjustment, plans would be more willing to provide information to and about persons with illness and would want to more actively involve their sicker patients to improve the plan's services and processes.

In summary, Dr. Luft stated that risk adjustment is not only about paying plans fairly but also establishes a mechanism by which plans can focus on improved outcomes, improved consumer involvement, and move the health care system towards having physicians and other health care professionals take care of their patients who really need help.

Ms. Shewry described how the Health Insurance Plan of California (HIPC), the state's small employer purchasing pool, uses risk adjustment. She said the HIPC was motivated by a desire to stop plans from seeking healthier enrollees, to protect plans that attract costlier patients, and to provide an incentive for health plans to specialize in treating patients who are sick.

Ms. Shewry stated that the HIPC enjoys some protections against risk segmentation (the ability for plans to selectively enroll healthier patients), such as guaranteed issuance and renewal, annual open enrollment, and fair marketing laws. She noted, however, that plans still have ways to segment risk. She also added that there are certain aspects of purchasing groups that make risk segmentation worse. First, the employee's ability to choose among plans means that certain types of patients may gravitate towards certain plans or certain types of plans. Second, as purchasers aggressively negotiate price, plans have an incentive to "scrimp" on quality to lower price. Therefore, the HIPC felt risk adjustment was necessary.

Ms. Shewry stated that the HIPC risk adjusts premiums based on age-stratified gender, 200 marker diagnoses, and the number of children per contract compared to the norm within the HIPC population. Under the HIPC's risk adjustment program, premium dollars are taken away from plans that have very favorable risk selection and given to plans that have unfavorable risk selection. Ms. Shewry stated that this information is not disclosed to consumers.

Chairman Enthoven asked Dr. Luft and Ms. Shewry for any suggestions they thought the Task Force should make regarding risk adjustment. Ms. Shewry felt that larger purchasers, such as CalPERS or PBGH, should institute risk adjustment. Dr. Luft stated that there are risk adjustment experiments happening in Medicaid and Medicare. Dr. Luft suggested that if health plans would pass some of the additional money they receive from risk adjustment on to their medical groups, the medical groups would have an incentive to report more data to the plans. However, he felt that the HIPC was not large enough to provide that kind of incentive to plans.

Based on these remarks, Chairman Enthoven suggested that the Task Force might recommend that CalPERS implement risk adjustment. A representative from the Department of Personnel Administration stated that CalPERS just released a request for proposals on this issue, but only with the intent of adjustments based on age. Chairman Enthoven explained that because of the state's current contribution structure, risk adjustment would probably actually cost the state money. For this reason, Dr. Luft assessed risk adjustment as more of a political issue than a technical issue.

Mr. Lee asked whether medical groups are risk adjusted and what administrative costs risk adjustment entails. Dr. Luft responded that medical groups are not receiving risk-adjusted payments because plans

are not generally receiving risk-adjusted payments. Ms. Shewry stated that administrative costs are not overwhelming because the audits are done on an annual basis and the advisory group is made up of volunteers. She stated that the high costs result from the necessary data infrastructure.

2. The Standardization of Health Benefits Packages [Linda Bergthold, Ph.D., Health Care Consultant; Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board] - 12:30 P.M.

Ms. Bergthold stated that sponsored groups (e.g., Medicare, HIPC, PBGH, CalPERS) are doing a lot of standardization. She presented a chart showing that approximately 95% of large employers in the US cover about the same services and that the variation in benefits is small but significant.

Ms. Bergthold felt that standardization is done for purposes of equity and simplicity. She stated that to help consumers choose among plans, the consumers ought to have the same financial protections no matter what plan they choose.

Ms. Bergthold discussed the disadvantages of standardization, including delaying the introduction of life saving technologies, raising costs for smaller self-insured firms, and discouraging innovations in benefit design – though she felt this last point was more rhetoric than reality.

Ms. Bergthold described categories of services that have the least standardized coverage, including mental health, substance abuse, prescription drugs, dental care, infertility services, abortion, and investigational/experimental treatments. She felt such services could be categorized as 1) services for which there is not good clinical consensus on standard treatment, 2) services which plans have good reason to want to avoid covering, or 3) services for which there are genuine value differences in society (e.g., abortion and infertility).

Ms. Bergthold stated that the degree of variability in coverage in California is driven mainly by mandates; she stated that California has relatively few mandates compared to other states. She suggested that the Task Force consider the issue of creating a core benefit as the basis for plan competition. She cautioned, however, that there would and should always be some variability until there is clinical agreement about what is safe and effective treatment for specific conditions. She felt that the standardized benefit package should be developed with consumer input.

Ms. Bergthold stated that benefit design "tinkering" has not been proven effective in lowering premiums. She urged the Task Force at the very least to make a statement about the need for benefit booklets to be understandable, including clarification of the term "medically necessary."

Lunch Break

PUBLIC COMMENT - 2:15 P.M.

1) **Mr. Thomas Swan**- an AIDS activist Mr. Swan described his own experience trying to access services related to the onset of blindness and commented on how some HMOs discriminate against AIDS patients. He called on the Task Force to recommend that HMOs not tolerate such discrimination, that HMOs institute training and advisory panels with AIDS patients, and that HMOs refer AIDS patients to specialists. He added that if he had been referred to an AIDS specialist sooner, his health plan would have saved money in the long run and he would be healthier and able to work.

Mr. Lee commented to the other Task Force members that one of the real challenges for managed care is caring for people who are "expensive" and that the responsibility of the health care system is to provide care for those who need it most.

2) **Mr. Keith Bishop** - Commissioner of the Department of Corporations Mr. Bishop announced to the Task Force that he would be resigning from the DOC, effective September 30th. He offered some final advice to the Task Force.

Mr. Bishop advised the Task Force to act on the basis of facts and to remember that "we are a country of laws." He also urged members to treat consumers with dignity and respect and to give consumers the authority to make autonomous decisions by leveling the playing field between group-purchased and individual-purchased health coverage.

Mr. Bishop thanked everyone for their work.

C. Expert Resource Group Report and Discussion -

1. Doctor-Patient Relationship (Members: Brad Gilbert, MD, Mark Hiepler, and John Perez).

This topic was moved for discussion at future Task Force meetings.

D. Perspectives on Managed Care - Presentations - 2:35 P.M.

1. California Academic Medicine [William H. Gurtner, Vice President, Clinical Services Development, University of California, Office of the President; Brian S. Bull, MD, Vice President of Clinical Faculty and Dean of Loma Linda University's School of Medicine; Jeffrey Huffman, President and CEO of USC's Care Medical Group; Kenneth Wolfe, Ph.D., Assistant Dean for Educational Affairs, Edgar University School of Medicine; and Joseph Hopkins, Stanford Health Services and Medical Director for Health Plans].

Mr. Gurtner felt that the early debates about managed care failed to take into account the domino effect managed care has on a broader set of assets owned and operated by the state of California. He stated that managed care has had a dramatic effect on the University of California and questioned whether Californians would be pleased with the end result. Mr. Gurtner stated that one of the products of the University of California is research, which is being impacted by managed care. He felt it would be a mistake for the Task Force to simply address these issues through a market approach. He advocated using a public policy approach that considers the implications for state resources.

Dr. Bull then addressed the issue of adverse selection. He said that adverse selection affects not only academic medical centers but all providers who are perceived to be of higher quality in the health care market. Dr. Bull also pointed out that non-white physicians are more likely to care for minority, medically indigent, and sicker patients. However, caring for less affluent and sicker patients may financially penalize non-white physicians and make them particularly vulnerable to capitation arrangements. He also stated that sick patients tend to seek out what they perceive as higher quality care while healthy patients choose among HMOs more or less randomly. Therefore, in his opinion, higher quality providers are penalized for their higher quality reputation because under managed care payment no longer travels with the individual patient. He felt that the system will, in time, self-destruct and presented an analysis of the financial changes that would be needed to address the issue.

Dr. Huffman identified several stresses resulting from managed care, including Medi-Cal managed care, patients being recruited out of the traditional academic medical center system, reimbursements well below costs, and Medicare managed care. He stated that his AMC has relatively recently developed a private medical group practice. He said that his organization (USC's Care) has succeeded in getting its practice and costs down which has allowed them to compete favorably in the market. He also said that it is mostly faculty members delivering medical services. However, these medical doctors are also the ones who teach undergraduate students. So as physicians compete more in the private sector, less time is devoted to the educational side. Dr. Huffman emphasized the societal benefits from quality education and medical research.

Dr. Wolfe said that faculty needs to understand the new health care system in order to be effective teachers as well as effective deliverers of health care education. Dr. Wolfe also stated that the method of reimbursement impacts the way individual providers practice. Under the traditional fee-for-service system, consumers wanted providers to do as little as possible to keep consumers' costs under control. Medical providers, on the other hand, wanted to do as much as medically justifiable to maximize the revenues. By contrast, Dr. Wolfe continued , under capitation consumers want providers to do as much as possible because their payments for the individual provider are fixed. Providers, on the other hand, want to provide only the minimum amount of service required to meet their medical responsibilities. Consumers have also started to demand accountability of outcomes for expenditures, creating economic disincentives for the use of academic medicine. He the impact that increased mergers between academic medical centers and managed care organizations will have on faculty structure, productivity, education, and research. He stated that his institution's philosophy is that preparations for the managed care environment has to occur throughout medical education, including undergraduate education, graduate education, residency training, and faculty development.

Dr. Hopkins stated that his AMC treats sicker, costlier patients, compared to the general population, but does not receive higher payments. He stated that patients who have the ability to switch plans every 30 days frequently transfer into his organization's care for the short time they need major procedures and then return to their previous provider when they are healthy. Under these circumstances, his organization receives just one or two months of capitation to cover the patients' major care. He added that physicians are being asked to see more patients and have less time for academic pursuits. Dr. Hopkins also discussed a published study that looked at the rate of National Institute of Health (NIH) grants for clinical research. He said the study found that in areas where managed care has a large penetration, NIH grants are decreasing He recommended preserving access to AMCs by expanding the centers of excellence concept, improving guidelines for referrals to AMCs, improving cooperation between community medical groups and AMCs, strengthening appeals processes, paying AMCs for the level of complexity of care they provide, and addressing the issue of frequent movement of patients between plans and groups.

V. DISCUSSION - 4:30 P.M.

A. Formulation of Policy Options Work Groups

Ms. Hattie Skubik, Deputy Director of Policy and Research at the Task Force, summarized the process outlined in Executive Director Romero's letter.

Dr. Rodriguez-Trias requested that the Task Force discontinue informational presentations. She suggested discussing key points either through the ERG or through working groups.

Mr. Lee supported Dr. Rodriguez-Trias' suggestion. He said that the Task Force needs time to talk about the proposals made by the working groups so the Task Force could reach a consensus on substantive

issues. Mr. Lee said that the whole purpose of the Delphi process is to be able to discuss the results publicly. Dr. Gilbert, Mr. Werdegar, and Ms. Finberg supported these positions.

On the topic of broad policy statements versus specific recommendations, Ms. Griffiths noted that the more specific the recommendations are, the more likely the resulting legislation will carry the same intent. However, she acknowledged that consensus on very specific recommendations is harder to achieve. Deputy Director Skubik advocated creating a range of possible recommendations, varying in their specificity and intensity.

VI. PUBLIC COMMENT- 4:55 P.M.

1) **Ms. Arlis Anderson Rothma**- the University of California Commission of the Future of Medical Education and the California Coalition of Nurse Practitioners. Ms. Rothma commented on the need for managed care organizations to support academic medicine. She also stated that many nurse practitioners and nurse midwives are having difficulties getting reimbursement through managed care.

2) **Ms. Lynnie Morgan**. Ms. Morgan felt that Dr. Luft's comments on risk adjustment were extremely encouraging from a consumer standpoint. She was concerned, however, that risk adjustment would focus on "politically correct" diseases such as AIDS and diabetes and would not address the needs of people who have difficulties obtaining a diagnosis or who have rare diseases. Dr. Spurlock and Chairman Enthoven discussed the possibility of carving out funds for rare diseases.

3) **Mr. Butley**- California Association of Catholic Hospitals. Mr. Butley discussed a policy paper related to universal health care coverage that he would submit to the Task Force in time for the November meeting.

VII. ADJOURNMENT [Chairman Enthoven] 5:05 P.M.

Hearing and seeing no objection, Chairman Enthoven declared the Study Session adjourned at 5:05 p.m.

Prepared by: Enrique J. Ramirez, Ph.D.